

HOUSE No. 905

By Ms. Balser of Newton, petition of Ruth B. Balser and others for legislation to limit annual costs charged to members of health maintenance organizations. Financial Services.

The Commonwealth of Massachusetts

PETITION OF:

Ruth B. Balser	Denise Provost
Steven J. D'Amico	Elizabeth A. Malia
Ellen Story	Kay Khan
Douglas W. Petersen	Jennifer M. Callahan
William N. Brownsberger	Barbara A. L'Italien
John P. Fresolo	David B. Sullivan

In the Year Two Thousand and Seven.

AN ACT REGARDING FINANCIAL PROTECTION FOR CONSUMERS ENROLLED IN HMOs.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

- 1 SECTION 1. Chapter 176G of the General Laws is hereby
- 2 amended by inserting after section 3 the following section:—
- 3 Section 3A. (a) As used in this section, the following terms shall
- 4 have the following meanings unless the context clearly requires
- 5 otherwise:
 - 6 “Co-insurance”, a percentage of costs paid by an insured for
 - 7 covered benefits, in addition to any prepaid premium amount.
 - 8 “Co-payment”, a predetermined fixed amount that an insured
 - 9 pays for covered benefits, in addition to any prepaid premium
 - 10 amount.
 - 11 “Cost-sharing”, any fees paid by the insured for covered benefits
 - 12 including co-payments, co-insurance and deductibles
 - 13 “Covered benefits” or “benefits”, health care services to which an
 - 14 insured is entitled under the terms of the health benefit plan.
 - 15 “Deductible”, the portion of an insured’s covered expenses that
 - 16 must be paid by the insured before any coverage or portion of cov-
 - 17 erage begins.

18 “Health benefit plan”, a policy, contract, certificate or agreement
19 entered into, offered or issued by a carrier to provide, deliver,
20 arrange for, pay for, or reimburse any of the costs of health care
21 services.

22 “Insured”, an enrollee, covered person, insured, member, policy-
23 holder or subscriber of a carrier, including an individual whose eligi-
24 bility as an insured of a carrier is in dispute or under review.

25 “Out-of-pocket maximum”, the maximum amount of cost-
26 sharing an insured must pay out-of-pocket for covered benefits
27 during a contract year, including any deductible, co-payment and co-
28 insurance amounts; once this limit is reached, all covered benefits
29 are paid for by the health maintenance organization up to the max-
30 imum level of coverage.

31 “Preventive health care”, any periodic, routine, screening or other
32 services designed for the prevention and early detection of illness
33 that a carrier is required to provide pursuant to Massachusetts or
34 federal law. This includes, but is not limited to, immunizations;
35 periodic health exams for adults and children, as well as those mam-
36 mograms, cytological exams and diagnostic tests associated with
37 periodic health exams; prenatal maternity care; well child care,
38 including vision and auditory screening; voluntary family planning;
39 nutrition counseling; and health education. Preventive health care
40 shall also include supplies, equipment, medication and specialist
41 provided treatments and services for insureds with chronic illnesses
42 and/or disabling conditions.

43 (b) Any health maintenance organization’s health benefit plan that
44 includes cost-sharing of any covered benefits shall include an out-of-
45 pocket maximum on all such health benefit plans. The out-of-pocket
46 maximum shall not be greater than the minimum annual deductible
47 that is consistent with the requirements for a high deductible health
48 plan as defined in section 223 of the Internal Revenue Code and
49 implementing regulations of guidelines.

50 (c) Any health maintenance organization’s health benefit plan that
51 imposes higher cost-sharing for specialist visits or tertiary care hos-
52 pitals shall allow insureds with chronic illnesses or disabling condi-
53 tions to pay the lower cost-sharing of the primary care provider or
54 community hospital.

55 (d) Deductibles may apply only to inpatient, outpatient and ambu-
56 latory treatment, but not to emergency care or preventive health care.

1 SECTION 2. (a) The department of public health and the division
2 of health care finance and policy are hereby directed to make an
3 investigation and study relative to the effects of high cost-sharing
4 health maintenance organizations on affected parties. These parties
5 include hospitals, the uncompensated care pool (as of October 1,
6 2007, the health safety net), and consumers. In respect to consumers,
7 the department and division shall analyze all relevant factors,
8 including but not limited to access to care, utilization, financial costs
9 and health status.

10 (b) The department and division shall report the results of the
11 investigation and study and recommendations, if any, together with
12 drafts of legislation necessary to carry out the recommendations to
13 the joint committee on health care financing, joint committee on
14 financial services, and the house and senate committees on ways and
15 means on or before January 1, 2009.

1 SECTION 3. If any provision of this Act or its application to any
2 person or circumstances is held invalid, the invalidity does not affect
3 other provisions or applications of the Act which can be given effect
4 without the invalid provision or application, and to this end the
5 provisions of this Act are severable.